

ORIGINAL

2 to 4

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

MANUEL RAMOS,
Plaintiff,

v.

MARGARET HARDEN,
DR. MCGLORI,
DR. MAXIMO R. VELASCO, JR.,
DR. PETER J. TERHAAR
Defendants.

CIVIL NO.: 1:00-CV-1957

(Judge Jones)

(Magistrate Judge Smyser)

FILED
HARRISBURG, PA

AUG 29 2003

MARY E. D'ANDREA, CLERK
Per

PLAINTIFF'S SUMMARY JUDGMENT EXHIBITS

Respectfully submitted,

Date: August 25, 2003



Andrew J. Ostrowski, Esquire
PA Id. #: 66420
4311 N. Sixth Street
Harrisburg, PA 17110
717-221-9500
Attorney for Plaintiff

COPY

FORM 7540-00-634-4152

PATIENT IDENTIFICATION (For typed or written or typed or written)
Name — last, first, middle, Medical Facility

RAMOS MANUEL

SEX (Sponsor)

WARD CLINIC

REGISTER NO.

37563-0

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)

Right Hand X-ray

REQUESTED BY

[Signature]

TELEPHONE NO.

PREGNANT

☐ YES ☐ NO

LOCATION OF MEDICAL RECORDS

USP Lewisburg

FILM NO.

12-43

DATE REQUESTED

12-4-97

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

Injury at elbow with a bone prominence at the
phalangeal phalange of thumb, right.

DATE OF EXAMINATION (Month, day, year)

12-12-97

DATE OF REPORT (Month, day, year)

12/14/97

DATE OF TRANSCRIPTION (Month, day, year)

12/14/97

RADIOLOGIC REPORT

RIGHT HAND:

Questionable small avulsion fracture is seen at the distal first metacarpal. Minimal deformity is seen at the ulnar styloid process probably related to old injury. The rest of the hand is otherwise unremarkable.

IMPRESSION: Questionable small avulsion fracture at the distal first metacarpal.

JAE SHIM, MD

SIGNATURE

Antonio Buendia, M.D./dh

LOCATION OF RADIOLOGIC FACILITY

1 - MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

*U.S.G.P.O. 1964-234-653

STANDARD FORM 519-A (REV. 8)
Prescribed by GSA/ICMR
FIRM (41 CFR) 201-45-505

IMPRESSION:

Normal chest.

SIGNATURE

[Signature]

LOCATION OF RADIOLOGIC FACILITY

1 - MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

*U.S. GOVERNMENT PRINTING OFFICE: 1990-273-272

STANDARD FORM 519-A (REV. 8)
Prescribed by GSA/ICMR
FIRM (41 CFR) 201-45-505

d&t: 10-28-96

SIGNATURE

[Signature]

Board Certification of Radiologist

1 - MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

*U.S. GOVERNMENT PRINTING OFFICE: 1993-361-197

STANDARD FORM 519-A (REV. 8)
Prescribed by GSA/ICMR
FIRM (41 CFR) 201-45-505

SIGNATURE

Exh. "A"

LOCATION OF RADIOLOGIC FACILITY

STANDARD FORM 519-A (REV. 8)

03/02/98 Manuel Ramos 37563-053

Manuel is a 54 year old Hispanic male who injured his right thumb while incarcerated at Allenwood facility eight to nine months ago. Apparently he was wrestled down to the floor by a guard and there was a jamming type of injury to the involved digit. He complained of significant pain ever since. He was recently evaluated by the PA on 2-9-98 and a radiograph did reveal an avulsion fracture involving the distal metacarpal at the ulnar collateral ligament attachment. Orthopedic consultation was appropriately ordered. On the chart the injury was dated as back in 1996.

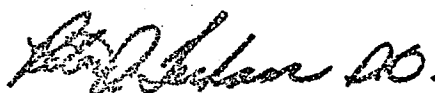
On physical examination, there was exquisite tenderness over the ulnar collateral ligament insertion on the metacarpal head, with a positive 2+ radial stress test. He has full range of motion of the involved metacarpal phalangeal joint.

Review of the radiograph revealed an avulsion fraction involving the ulnar aspect of the metacarpal head.

Impression: 1. Gamekeeper's thumb with Grade III injury to the ulnar collateral ligament.

Plan: With a Grade III injury, there is incarcerated adductor pollicis muscle underneath the ulnar collateral ligament. Therefore, surgical reattachment is indicated. Therefore, we would prefer to use suture anchors, and would create a bony trough in the metacarpal head for repair, extricating the adductor muscle. The risks were discussed fully with the patient, including the risk of postoperative stiffness, infection, nerve and artery damage. The patient does work as an orderly, and this does involve significant physical work, which would be difficult to perform with this current condition. PJT/mew

cc: Dr. Velasco



Exh. B

| MEDICAL RECORD | | CONSULTATION SHEET | |
|--|---|---------------------------------|---------------------------|
| TO: <u>Orthopedic clinic</u> | FROM: <u>Requesting physician or activity</u> <u>Plasma</u> | DATE OF REQUEST <u>02-09-98</u> | |
| REASON FOR REQUEST: <u>Pain (R) 1st finger</u> | | | |
| Prior Treatment: <u>NONE</u> | | | |
| Current Medications: <u>NONE</u> | | | |
| Allergies: <u>NKDA</u> | | Date of Birth: | |
| Significant PMH: <u>Noncontributory.</u> | | | |
| Significant Objective Findings: <u>Deformed, Swollen (R) 1st finger, noted tenderness on palpation</u> | | | |
| PROVISIONAL DIAGNOSIS: <u>avulsion fracture of the distal metacarpal base</u> | | | |
| DOCTOR'S SIGNATURE <u>M. Velasco</u> | | APPROVED | To be seen no later than: |
| Maximo R. Velasco Jr., M.D. Medical Officer | | CONSULTATION REPORT | |
| Consultant Findings: | | | |
| <u>Found at Menard 8-9 yrs ago</u> | | | |
| <u>PE = Gradual stress</u> | | | |
| <u>" Pteridium UCL</u> | | | |
| <u>gross Grade III Carpal tunnel</u> | | | |
| Assessment: <u>How</u> | | | |
| Plan: <u>Would recommend surgical repair to bone.</u> | | | |
| <u>Risks discussed</u> | | | |

Medical Category: Please check one of the categories below whenever there is a recommendation for diagnostic studies or treatment which will result in transportation of the inmate outside of the institutions:

- () Medically Mandatory: immediate, urgent or emergency care required to maintain or treat a life threatening illness or injury.
- () Presently Medically Necessary: treatment that cannot be reasonably delayed without causing further complication, serious deterioration, significant pain or discomfort.
- () Medically Acceptable But Not Medically Necessary: for the convenience of the inmate.

Follow Up:

- () No Additional Follow Up By Consultant Required At This Time. Patient To Be Followed Up By Institution Staff PMH.
- () Schedule Patient For Next Appointment No Later Than _____.

Patient Education:

- () Etiology () Treatment Alternatives & Prognosis

SIGNATURE AND TITLE

M. Velasco
Maximo R. Velasco Jr., M.D.
Medical Officer

DATE

3/2/98

IDENTIFICATION NO.

ORGANIZATION

USP Lewisburg, Lewisburg, PA 17837

REGISTER NO.

WARD NO.

PATIENT'S IDENTIFICATION

Ramos, Manuel

- - - - - M E R

Exh. C

CONSULTATION SHEET

Medical Record

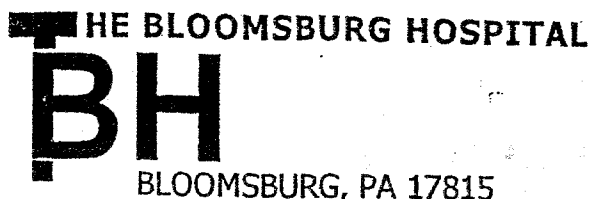
STANDARD FORM 513 (REV. 8-72)

(W) 213

OR CHECK SHEET

| | | | | | |
|-----------------------------------|--------------------------------------|----------------|----------|------|----|
| Name: | Manuel Ramos | | | Age: | 53 |
| Procedure: | Repair gamekeeper's thumb right hand | | | | |
| Surgery Date: | June 11 | | | | |
| Hospital: | Blom | | | | |
| SPU () | SDA () | Family Doctor: | | | |
| Surgery Scheduled at OR: | DATE | | INITIALS | | |
| Pre-admission testing: | 5/11 | | | | |
| Autologous: | info faxed to Karen (523-9336) | | | | |
| Standing Knee Film: | | | | | |
| Admission Notified: | | | | | |
| Surgical Consents Signed: | | | | | |
| Health History Completed/Updated: | | | | | |
| Physician Orders Completed: | | | | | |
| Special Equipment Ordered: | | | | | |
| Polar Care () | RBC Saver () | | | | |
| CPM () | Template () | | | | |
| Hardware (ie prosthetic) () | | | | | |
| Pre-op Clearance: | 6-10-98 | | | | |
| Physician to Assist: | Surgery cancelled because of heart | | | | |
| OR Notified of Assist: | then done - spoke w/ Karen | | | | |
| Pre-cert Completed: | not done - he will cancel | | | | |
| Hospital Notified of Pre-cert: | Services - he will cancel | | | | |
| Sent to Hospital: | Call to reschedule | | | | |
| Surgical Consents: | | | | | |
| Physician Orders: | | | | | |
| Physician Progress Note: | | | 1/6 | | |
| X-rays: | | | | | |
| History & Physical Dictated: | | | | | |

Exh. D



REPORT OF OPERATION

RAMOS, MANUEL
 Bill No: 30105068
 MR No: 289236

Surgery Date: 01/07/1999
 Surgeon: Peter J Terhaar, D.O.
 Assistants: None

Attending Physician: Peter J Terhaar, D.O.

Patient Location: 2STH 210

Preoperative Diagnosis: Chronic gamekeeper's thumb, right upper extremity (Grade III).

Postoperative Diagnosis: Chronic gamekeeper's thumb, right upper extremity (Grade III).

Operation: repair of gamekeeper's thumb, right hand, with reconstruction ulnar collateral ligament utilizing a palmaris longus tendon graft with suture anchors. Application of a thumb spica splint.

Findings and Procedures:

Gross pathology: preoperatively, this patient had signs, symptomatology and clinical evidence consistent with the aforementioned diagnosis. He had severe chronic instability involving the right thumb metacarpophalangeal joint. Intraoperatively, the ulnar collateral ligament was noted to be severely attenuated and redundant. It was not suitable for repair; therefore, a palmaris longus graft was taken from the ipsilateral extremity and utilized for reconstruction. This was attached to both the 1st metacarpal as well as the proximal phalanx utilizing suture anchors. Prior to the reconstruction, the joint could be gapped open approximately 45 degrees with very little stress. Intraoperatively after the graft was inserted, 5 degrees of stress was, this was quite stable, and only 5 degrees of excursion was obtainable.

Procedure: the patient was taken to the operating room where he was sterilely prepped and draped in the usual manner. The patient was identified, the operative site was verified. The patient was under general endotracheal anesthesia. The tourniquet was inflated about the right upper arm to 225 mmHg. Attention was turned to the right hand where the curvilinear incision was made over the 1st metacarpophalangeal joint. Sharp dissection carried on down to the extensor expansion. The adductor pollicis tendon and muscle were identified. Close inspection revealed a redundant ulnar collateral ligament underneath. The capsulotomy was then carried out and the proximal metacarpal base as well as the ulnar aspect of the proximal phalangeal base as well as the ulnar aspect of the metacarpal head were freshened up utilizing a rongeur. This was then further freshened utilizing a K-wire to provide a nice bleeding surface for reattachment of the tendon graft. After this was carried out, attention was turned to the palmaris longus which was harvested through two small stab incisions. This was then sutured to the bone with the aid of suture anchors utilizing 2.5 mm Zimmer Statak suture anchors over the metacarpal head and proximal phalanx. An excellent stable construct was achieved. Approximately 5 degrees of excursion could be achieved with radial stress. Following this, the ulnar capsule was imbricated utilizing 4-0 nylon suture sewing part of this into the adductor pollicis tendon. Irrigation was carried out within the wound several times before closure. The wound was closed with 5-0 nylon suture. Xeroform was applied followed by 4x4s, sterile Adaptic, sterile Webril, and a thumb spica splint was then applied with the thumb held in adduction. The tourniquet was

Report of Operation

Page 1 of 2

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Copy for Peter J Terhaar, D.O.

Exh. E

THE BLOOMSBURG HOSPITAL

BH

BLOOMSBURG, PA 17815

REPORT OF OPERATION

RAMOS, MANUEL

Bill No: 30105068

MR No: 289236

deflated at the end of the procedure. The case was clean, classification elective, blood loss none, specimens none.

Disposition: the patient is discharged back to the Lewisburg facility with full instructions to ice and elevate the involved extremity prn pain and swelling for 20 minutes each waking hour times 48 hours, to call if he has any problems, to change the dressing and remove the sutures in approximately seven to ten days and reapply the splint at that time. I will follow-up with the patient at the facility within the next four weeks. Full instructions were given to leave the splint in place for approximately six weeks from today's date. Orders were written for Tylenol #3, two q. 4 hours prn pain. He is not to lift, not to drive, and to sponge bathe only.

Dictated by: Peter J Terhaar, D.O.

cc: Peter J Terhaar, D.O.

*Dr. Bussanich

Lewisburg Correctional Facility
Lewisburg, PA 17837

PJT:cc

Doc#: 12820

Job#: 0043

D: 01/07/1999; 10:04 A

T: 01/07/1999 11:16 A

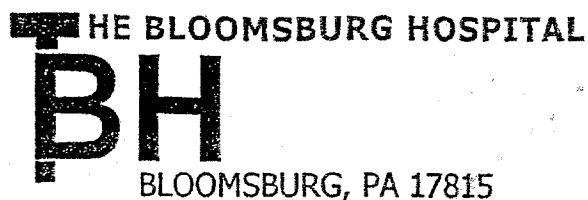
Report of Operation

Page 2 of 2

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Exh. E



HISTORY AND PHYSICAL EXAMINATION

RAMOS, MANUEL
Bill No: 30105068
MR No: 289236

Admission Date: 01/07/1999

Attending Physician: Peter J Terhaar, D.O.

Dictating Physician: Peter J Terhaar, D.O.

Patient Location: 2STH 210

CHIEF COMPLAINT: Manuel is a 54-year old Hispanic male, inmate of Lewisburg Correctional Facility, who injured his right thumb while incarcerated at Allenwood Facility approximately 18-19 months ago. He was wrestled down to the floor by a guard and there was apparently a jamming type of injury to the involved digit. He complained of significant pain and instability to the joint ever since. Radiographs taken on 2/9/98 revealed a navulging fracture involving the distal metacarpal at the ulna collateral ligament origin. It was felt that he would benefit from operative intervention.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Unobtainable at the present time.

MEDICATIONS: Unknown at the present time.

REVIEW OF SYSTEMS: Unknown at the present time.

PHYSICAL EXAMINATION:

HEENT: Normocephalic for patient's age and body habitus. PERRLA. EOMI.

HEART: Heart rate is regular and rhythmic without murmurs. Negative S3, S4.

LUNGS: Clear to auscultation in all fields. Negative rails, negative rhonchi.

ABDOMEN: Bowel sounds physiologic in all quadrants. Negative rebounding, negative tenderness, negative masses noted.

GENITOURINARY/RECTAL: Deferred.

EXTREMITY EXAMINATION: There was exquisite tenderness involving the ulnar collateral ligament origin on the metacarpal head with 2+ positive radial stress test. He had full range of motion of the involved metacarpal phalangeal joint. Review of the radiographs reveals a navulging fracture involving the ulnar aspect of the metacarpal head.

IMPRESSION:

Game Keeper's Thumb with a Grade 3 Injury involving the Ulnar Collateral Ligament.

PLAN:

It was felt that he would benefit from operative intervention. We will explore the condition of the ulnar collateral ligament. This is extremely attenuated. We will likely perform a palmares longus graft to reconstruct the ligament. He was informed of the risks, complications, expected benefits, recovery period associated with the procedure, including the risk of infection, nerve and artery damage, reaction to the anesthesia, such as nausea, vomiting, allergies, the risk of recurrence and so forth. Consents were signed. Questions were answered. He is scheduled for the surgical procedure.

History and Physical Examination

Page 1 of 2

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Copy for Peter J Terhaar, D.O.

Exh. F

U.S. MEDICAL CENTER FOR FEDERAL PRISONERS
SPRINGFIELD, MISSOURI

HISTORY AND PHYSICAL

RAMOS, Manuel
Reg. No. 37563-053
May 24, 2000
WARD: 1-3

It should be noted information was obtained via the language interpreter, Lisa Lewis.

HISTORY - PART I

CHIEF COMPLAINT: Right carpal tunnel syndrome.

HISTORY OF PRESENT ILLNESS: This 55-year-old Colombian male was referred from USP Florence, Colorado. The patient gives the history of an initial thumb injury in 1997 and has been evaluated previously by Orthopedic Surgeon, Dr. Peter Terhaar, in Bloomsburg, Pennsylvania, and underwent repair of gamekeeper's thumb of the right hand with reconstruction of ulnar collateral ligament. This was done on January 7, 1999. Since his surgery, the patient has consequently developed right hand paresthesia involving the right thumb, index, long finger, and lateral portion of ring finger. EMG and NCV studies done May 11 revealed moderate to severe right carpal tunnel syndrome.

HISTORY - PART II

OCCUPATION: Incarcerated for eight years. Previously worked as a cab driver.

MILITARY HISTORY AND FOREIGN TRAVEL: Native Colombian.

HABITS: Alcohol: History of abuse.
Tobacco: History of 60 pack years, quitting 16 years ago.
Drugs: Denies IV drug use.

EDUCATION: First grade.

FAMILY HISTORY:

Father: Deceased from murder.
Mother: Deceased secondary to old age.
Siblings: Three brothers and one sister living and well.

Patient denies family history of cancer, tuberculosis, diabetes, heart disease, blood disorders, seizure disorder, kidney disease, or mental illness.

Kevin J. Kelly, Certified Physician Assistant

RAMOS, Manuel

Exh. G

May 24, 2000

Reg. No. 37563-053

GAMEKEEPER'S THUMB

Matthew Hannibal, MD, Staff Physician, Department of Orthopedics, St Vincent's Catholic Medical Center, Albert Einstein School of Medicine

Coauthor(s): Daniel Roger, MD, Assistant Professor, Department of Orthopedics, Catholic Medical Center of Brooklyn and Queens, New York Medical College

Editor(s): Peter M Murray, MD, Associate Professor of Orthopedic Surgery, Mayo Graduate School of Medicine; Education Coordinator, Department of Orthopedic Surgery, Division of Hand & Microvascular Surgery, Mayo Clinic of Jacksonville; Francisco Talavera, PharmD, PhD, Senior Pharmacy Editor, Pharmacy, eMedicine; Michael Yaszemski, MD, PhD, Associate Professor, Departments of Orthopedic Surgery and Bioengineering, Mayo Foundation, Mayo Medical School; Dinesh Patel, MD, Assistant Clinical Professor of Orthopedic Surgery, Harvard Medical School; Chief of Arthroscopic Surgery, Department of Orthopedic Surgery, Massachusetts General Hospital; and Harris Gellman, MD, Clinical Professor of Orthopedic Surgery, University of Arkansas and University of Miami; Consulting Surgeon, Broward Hand Center Abrahamsson SO, Sollerman C, Lundborg G: Diagnosis of displaced ulnar collateral ligament of the metacarpophalangeal joint of the thumb. *J Hand Surg [Am]* 1990 May; 15(3): 457-60 Campbell CS: Gamekeeper's thumb. *J Bone Joint Surg* 1955; 37: 148-9. Gerber C, Senn E, Matter P: Skier's thumb. Surgical treatment of recent injuries to the ulnar collateral ligament of the thumb's metacarpophalangeal joint. *Am J Sports Med* 1981 May-Jun; 9(3): 171-7[Medline]. Heyman P: Injuries to the ulnar collateral ligament of the thumb metacarpophalangeal joint. *J Am Acad Orthop Surg* 1997 Jul; 5(4): 224-9. Newland CC: Gamekeeper's thumb. *Orthop Clin North Am* 1992 Jan; 23(1): 41-8[Medline]. Pichora DR, McMurtry RY, Bell MJ: Gamekeepers thumb: a prospective study of functional bracing. *J Hand Surg [Am]* 1989 May; 14(3): 567-73[Medline]. Sollerman C, Abrahamsson SO, Lundborg G: Functional splinting versus plaster cast for ruptures of the ulnar collateral ligament of the thumb. A prospective randomized study of 63 cases. *Acta Orthop Scand* 1991 Dec; 62(6): 524-6[Medline]. Stener B: Displacement of the ruptured ulnar collateral ligament of the metacarpo-phalangeal joint of the thumb: a clinical and anatomic study. *J Bone Joint Surg [Br]* 1962; 44: 869-79

Last Updated: May 13, 2002

Synonyms and related keywords: metacarpal fracture and dislocation, metacarpophalangeal joint dislocation, MCP joint dislocation, phalangeal fracture, skier's thumb, instability of the thumb, Stener lesion, ulnar collateral ligament tear, UCL tear, thumb injury, thumb pain, gamekeeper's fracture, thumb instability

Problem: Gamekeeper's thumb is clinical instability of the first MCP joint caused by an insufficiency of the ulnar collateral ligament (UCL) in the MCP of the thumb. Because the stability of the thumb is important for prehension, treatment is directed toward optimizing the healing of the ligament to restore its full function.

Nonsurgical treatment can be considered for partial tears, that is, grade I or grade II tears, of the UCL. These tears usually involve an isolated rupture of the proper collateral ligament.

Complete ruptures of the UCL can be determined by means of physical examination, including stress testing. Radiographic stress testing can be performed, but the evaluating surgeon should perform these tests

Exh. H

because stress radiographic findings can be misleading.

Contraindications: In this disorder, no absolute contraindications to surgery exist.

Relative contraindications include the following: The patient is too infirm to tolerate surgery, regardless of whether a complete UCL tear is present; gamekeeper's thumb is present in a child, with less than 2 mm of displacement of the Salter-Harris type III fracture; and chronic instability of the thumb due to a chronic UCL rupture is present.

Chronic instability of the thumb due to a chronic UCL rupture is difficult to treat, and repair using the capsuloligamentous structures of the ulnar border of the MCP joint has limited success. Even surgical repair performed 6 weeks after the complete UCL rupture has limited success. **Essentially, the longer a complete rupture of the UCL exists, the smaller the possibility of stability restoration with anatomic repair.**

Some surgeons have reported success with the dynamic transfer of a tendon such as the adductor pollicis from its insertion onto the ulnar sesamoid to the ulnar base of the proximal phalanx. Others have reported success with the use of static tendon transfers, which have the theoretic advantage of an inherent blood supply if some continuity of the tendon with its musculotendinous unit is preserved. Some surgeons even recommend MP fusion in cases of chronic gamekeeper's thumb; others reserve this procedure for use in those with concomitant osteoarthritis.

Preoperative details: Determine whether the UCL tear is partial or complete prior to surgical repair. Also, ~~determine whether the~~ UCL tear is chronic or acute, because the procedure may be different if the UCL tear is chronic.

Radiographs should be available for assessing the presence of a fracture or subluxation of the MCP joint. If the fracture fragment is large and/or displaced or if it represents more than 10% of the articular surface, fixation is required. **Small displaced avulsion fractures may be excised.**

Intraoperative details: Make an incision over the ulnar border of the MCP joint of the thumb. Incise the adductor aponeurosis longitudinally and retract it distally. Then exposed the dorsal capsule, and assess the proper and accessory collateral ligaments. During the surgical dissection, take care to identify and protect the sensory branch of the radial nerve; it is commonly seen within the surgical field. Even with careful dissection and retraction, the radial nerve neurapraxia can still occur postoperatively.

If the joint is subluxed and if the soft-tissue repair seems insufficient to hold the reduced joint, a small-gauge Kirschner wire (ie, K-wire) can be inserted to maintain the MCP joint in position. The UCL can then be repaired. In a fresh injury, the torn ends of the UCL can be directly repaired. If this approach is not possible, other possible techniques include the attachment of the ligament to the periosteum, its reattachment to the bone by using a pull out wire, or its fixation via the periosteum and bone flap. After the UCL is repaired, reattach the adductor aponeurosis. If a small piece of avulsed bone is present, remove it; a large bone fragment should be reduced and preserved.

For chronic UCL tears older than 6 weeks, consider repairs using the capsuloligamentous structures on the ulnar border of the MCP joint. If no degenerative changes are present at the MCP joint, consider ligament reconstruction. A free tendon, usually the palmaris longus, can be woven through the metacarpal neck and the base of the proximal phalanx. If arthritis is present or if the patient is a manual laborer, consider an arthrodesis of the MCP joint. Arthrodesis does not lead to significant impairment if the motion of the IP and carpometacarpal (CMC) joints is maintained.

Postoperative details: Postoperatively, place the patient's thumb in a spica splint, and begin carefully monitored ROM exercises of the IP and MCP joints. Alternatively, total cast immobilization for 4 weeks can be used. At 4 weeks after surgery, a removable thumb spica cast can be fabricated, and light activities

H

of daily living (ADLs) can be initiated. The brace should be removed only for performing exercises and hygiene. At 3 months after surgery, the patient's full activities can be resumed.

Follow-up care: After 4 weeks, the thumb spica and any pins that were placed may be removed. A hand-based splint that immobilizes the MCP joint is then applied for 2 weeks. The splint is removed for therapy during this 2-week period, and active motion of the MCP joint is begun. Unrestricted usage is begun at 3 months.

~complications

Chronic instability is a complication of UCL rupture. The common cause is the patient's failure to seek medical attention for diagnosis and treatment in a timely fashion. The longer a complete UCL rupture exists, the more likely it is to progress to chronic instability, even after its repair. Success in repairing the tissues after 6 weeks has been limited. The dorsal capsule, as well as the extensor pollicis brevis and extensor pollicis longus muscles, becomes attenuated, adding to the dorsal instability of the MCP joint. The thumb then tends to become displaced volarly and rotate into a supinated position.

Chronic instability of the MCP joint can occur despite a good repair, especially if motion and return to play are resumed prematurely. This instability is difficult to treat and can lead to arthritic changes in the MCP joint, as well as a weak pinch grasp in the long term.

Stiffness of the MCP and IP joints is a common complication. This stiffness is usually not a functional problem, and it tends to improve with time.

Neuropraxia of the radial sensory nerve may occur, even if care is taken to isolate and protect the nerve. The neuropraxia usually resolves spontaneously.

~outcome and prognosis

Early diagnosis is the most important factor that determines the functional outcome. In thumbs with partial ligament injuries, nonsurgical treatment by means of immobilization yields a stable, painless thumb with nearly normal motion in most cases. In more than 90% of complete ruptures that are surgically treated within 3 weeks of the injury, a good-to-excellent result can be expected.

Pain and stiffness can be expected to be mild or absent, and pinch and grip strength will be nearly normal. The rate of return to former activities, including recreational sports, is reported to be as high as 96%.

The failure to diagnose this injury and the patient's failure to seek medical treatment are the most common reasons for a poor outcome.

In complete tears, the failure rate of treatment with bracing and early motion is 50%. If a patient is unable to tolerate or refuses surgery, the use of a brace or thumb spica is the treatment of choice. However, full stability of the thumb is unlikely.

The prognosis for all repairs and reconstructions undertaken more than 6 weeks after a complete UCL rupture is poor.

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Commonly Missed Orthopedic Problems

**MICHAEL T. BALLAS, M.D., JAMES TYTKO, M.D.,
and FRANK MANNARINO, M.D., Dayton, Ohio**

**Ulnar Collateral Ligament Tear
(Gamekeeper's Thumb.)**

Ulnar collateral ligament tear ...is frequently overlooked and underdiagnosed. It is important to diagnose complete tears early because results of early surgical repair (within two to three weeks of the injury) are superior to results of late repair. Untreated tears can cause disabling instability of the hand, since the ulnar collateral ligament stabilizes the first metacarpophalangeal joint when the thumb is adducted against the index and middle fingers when gripping objects.

Ideally, radiographs should be taken before stress testing because, if an avulsion fracture is present, stress testing may further displace it. Stress radiographs (stress tests performed under x-ray) can help assess the degree of deviation but are not definitive.

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Orthop Rev. 1994 Oct;23(10):797-804.

Gamekeeper's thumb. Early diagnosis and treatment.

Kozin SH, Bishop AT. Department of Orthopaedic Surgery, Temple University School of Medicine, Philadelphia, Pennsylvania.

Injuries to the ulnar collateral ligament complex in the thumb are common and require prompt attention. Early diagnosis is essential and must differentiate a partial ligament sprain from a complete disruption. Accurate diagnosis requires a precise examination and roentgenographic evaluation. Provocative maneuvers and stress radiographs may be necessary to delineate the extent of injury. Partial injuries are treated effectively by thumb spica immobilization. Complete ruptures require operative intervention and anatomic repair. To optimize outcome, the operative procedure requires meticulous technique and should result in minimal morbidity. Late ulnar collateral ligament reconstruction is more complicated and inferior to early surgical repair.

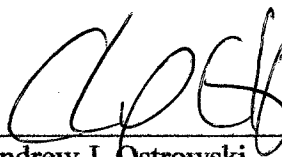
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CERTIFICATE OF SERVICE

I, Andrew J. Ostrowski, hereby certify that the foregoing document is being served by first-class mail, addressed as follows:

Michael Thiel, Esquire
Assistant United States Attorney
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